UTAH MEDICAID NURSING FACILITY
State Fiscal Year 2014
QUALITY IMPROVEMENT INCENTIVE (2)(ix) APPLICATION
Improved Dining Experience, Rule R414-504-4

This form and all supporting documentation must be postmarked or faxed on or before May 31, 2014

Facility Name: _____

Medicaid Provider I.D. _____ Administrator: _____

Please mark all that are complete:

☐ This facility used innovative means to improve the residents' dining experience. These changes my include
- Meal ordering,
- Dining times or hours,
- Atmosphere,
- More food choices etc.

☐ A detailed description of the dining improvements is attached.

☐ The dining improvements were paid for by May 31, 2014.

☐ The dining improvements were implemented between July 1, 2012 and May 31, 2014.

☐ Proof of purchase that includes receipts and invoices, is also attached. This includes proof of payment, i.e. cancelled check(s), financial debt instrument, etc.

Qualifying facilities may receive up to $200 per Medicaid Certified bed under this incentive (count as at 7/1/2013). This incentive is part of incentive (2). The maximum a facility may receive from all incentives in incentive (2) combined, is $580.18 per Medicaid Certified bed (count as at 7/1/2013).

Facilities will not receive more than was expended under this incentive.

Attach Spreadsheet for detail expenditures.

Total Reimbursement Requested (should match spreadsheet): $_____

Please ensure that all the supporting documentation is included. Failure to include all of the above detailed information will prevent the facility from qualifying.
By submitting this application I certify that all of the above criteria have been met.

Administrator Signature: _____ Date: _____

Note: Division staff will not request additional information relating to this submission. Please be sure to include all necessary information in order to qualify. Fax to: 801-323-1595 <or> Mail instructions: http://health.utah.gov/medicaid/stplan/longtermcare.htm

For Medicaid use only:		
Amount reimbursed	Maximum per-bed payout:	Date Paid